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ABSTRACT

Experience gathered to date confirms that capitation of Medicare does not necessarily decrease quality of health care and may in fact encourage an improvement in health care quality. Incentives inherent in capitated reimbursement are threefold. First, practitioners, by not receiving more payment for more service, are discouraged from providing unnecessary treatment. Second, capitation rewards the provision of needed services in the most efficient model possible. Finally, under capitation, underservice financially disadvantages the provider thus discouraging practitioners from avoiding necessary treatment. The very poor elderly who cannot afford to participate in most Medicare capitation programs also cannot afford the fee-for-service Medicare alternative. While the needs of the very poor should be met by the government, capitated systems can help to prevent or ameliorate poverty. Many of the frail elderly are in need of caring, rather than curative, services. Capitated systems offering coordinated services may efficiently address the needs of this population. The greatest single risk for financial catastrophe is the risk of institutionalization in a nursing home. Capitated systems may be able to develop and implement an effective insurance plan for long-term care. There is a need to direct attention first to creating effective means of monitoring quality that assure identification and correction of problems and second to adapting health programs to the needs of an aging population. (NB)

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CAPITATION OF MEDICARE: QUALITY CARE OR
THIRD-CLASS CARE FOR THE POOR

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I appreciate the opportunity to participate in this provocative session, particularly because I represent an organization celebrating its fortieth anniversary and with it a long and illustrious history of leadership in health care. Our success and innovation in programs for seniors and for the poor is consistent with our other accomplishments. As the first Medicare capitation contract in the country begun over a decade ago and with a Medicaid capitation contract begun in 1970, we would like to share our experience during today's debate.

My comments are made from the admittedly biased perspective of a fully integrated, staff model prepaid group practice - the old style Health Maintenance Organization or HMO. That bias, and our particular success, is augmented further by our organizational structure as a consumer cooperative. However, let me assure you my comments do not apply solely to such an unusual pedigree.

For the sake of discussion, I propose it may be more useful to consider separately the poor and the frail elderly. I will comment on the effects of capitation on quality of care for the poor elderly and for the frail elderly and will add a category not mentioned in the conference material - the elderly who are none of the above, neither poor nor frail. Finally, the category listed as the vulnerable elderly I find a less useful descriptor since it could apply to all three, and I will not distinguish it in my comments.

Experience gathered to date confirms that capitation in and of itself does not decrease the quality of health care. In fact, the incentives operating under capitation may encourage an improvement in the quality of health care. At the risk of oversimplifying, the incentives inherent in capitated reimbursement are threefold:

1. Don't provide unnecessary treatment,
2. Provide treatment through the most efficient combination of resources available, and
3. Don't avoid necessary treatment.

Let me speak to each of these basic principles.

If a practitioner does not receive more payment for more services, the financial incentive to do more is reduced. The research literature is replete with examples of regional variations in practice patterns with no obvious reason for the differences. We also recognize the risks inherent in medical practice itself, leading to the conclusion that to provide treatment that is not needed increases the hazard to a patient. In theory, at least, capitation encourages practitioners to reduce the level of unnecessary procedures, reducing, in turn, the level of risk.

Capitation also rewards the provision of needed services in the most efficient model possible. I would suggest that the more integrated models of HMOs such as the Cooperative are in an advantaged position to maximize these efficiencies since we own and operate our own hospitals, home health agency, skilled nursing facility, and medical centers.

Finally, is it likely that capitation will reward practitioners for underservice, for holding back on needed health care? If one follows the ultimate logic of capitation, underservice financially disadvantages the provider. For by withholding needed health care, the patient becomes more sick and needs more expensive health services. This, in turn, costs more and consumes a greater share of what could have been financial savings for the practitioner.

What objective evidence exists that these principles are valid? Unfortunately almost no research on this subject has included Medicare beneficiaries. However, there would appear to be no logical reason that capitation would affect the outcomes of medical practice differently for older than for younger persons.

In fact, a host of research has been completed on various categories of medical outcomes for non-seniors. The research consistently confirms that outcomes for patients treated under capitated systems are not of a lower quality, and, in some cases, are of a better quality than that provided under fee-for-service reimbursement. The most recent example of such research is

the \$90 million Rand study which used our plan, Group Health Cooperative, as the HMO study site. The Rand results show yet again that an HMO can reduce health care costs by approximately 25% without affecting the quality of care provided. And as in past studies, the primary reduction was achieved through elimination of unnecessary hospitalizations and enhancement of health promotion programs.

Although capitation in itself does not reduce quality of care, inadequate capitation may. The same may be said for inadequate fee-for-service reimbursement. I would suggest that the Medicare program is not yet such a poor payor under either system that quality of care is affected; I am not as assured about Medicaid payments. Since Medicaid payments for senior services in many states exceeds 40 percent of the Medicaid budget, the program should also be of interest to this discussion.

Currently we are conducting research on the use and costs of health services for Medicaid populations, both within and outside an HMO. Our own reasons for conducting the research are multifold. But one prominent concern is that the Medicaid program is hoping to reduce its costs by enrolling Medicaid recipients in HMOs, assuming that the HMO can transfer its proven track record in reducing health costs without reducing quality. However, we start from a very different situation with this population. The fee-for-service payments are inadequate, already discounted by at least 40%. The population has been documented to need higher levels of health care and to experience limited access to services in the fee-for-service community because of the low reimbursement rates. It is unrealistic, then, for the program to believe the HMO can solve the inadequacies of the current system at a price below that of the current inadequate fee-for-service levels. Capitation cannot possibly meet such unrealistic expectations.

What other measures of quality of care exist for us to consider? To date, both Medicare and Medicaid conduct quality reviews for all participants in their programs. With their results in hand, both Medicare and Medicaid are promoting expansion of capitated programs. In all fairness, though, most of the reviews of fee-for-service as well as capitated programs have focused on only hospital services. For several years now, the HMO industry has sought

expansion of such reviews to all settings to assure that all health services are of high quality and all outcomes reflect the appropriate combination of services.

Legislation passed in 1986 has institutionalized the request of the HMO industry. In a program that was supposed to begin in April, which is now hopelessly behind schedule, care provided in HMOs for Medicare beneficiaries will be reviewed in the inpatient, the outpatient, and all alternative settings. We are both excited and frankly nervous about this new program - excited because it makes sense and nervous both because the fee-for-service community will not be subject to comparable review and the approaches have not yet been developed to conduct the reviews. Although such reviews are much easier to conduct in capitated systems, we cannot fail to critique the outcomes and quality of care provided to the far greater portion of seniors who do not participate in HMOs or capitated systems.

The comments I have made so far focus on all of the categories I specified at the beginning of my speech, namely the seniors, the poor elderly, and the frail elderly. Perhaps some brief comments on the latter two categories would be appropriate.

The very poor elderly cannot afford to participate in most Medicare capitated programs, although some programs are offering comprehensive health services for a \$0 premium. But the very poor elderly also cannot afford the fee-for-service Medicare alternative with its high deductibles, copayments, and disallowed charges. I believe the circumstances and needs of very poor members of our society - whether elderly or not - need to be met by our government which has the advantage of access to the combined resources we all provide through taxes. Indeed, what better task have we for a government to undertake. And I hasten to add that my beliefs about this role do not apply purely to health care but to the other components necessary for basic support, including housing, food, clothing, and shelter. The failure of our government to meet these needs has led many of us, HMO and non-HMO alike, to create special programs to meet some of these needs.

What a capitated system can achieve is perhaps, ultimately, more valuable. We can help prevent or ameliorate poverty. First, no member of our plan ever receives a catastrophic health bill, a potential cause of poverty. Second, the community-rated premiums used in capitated systems average the cost of low and high users of care. Thus, the older members of our senior community are not charged the significant rates that would reflect their high use of needed services. Let me put aside for the moment a third strategy, namely long term care insurance, which really addresses both the frail and potentially impoverished members of our community.

The frail elderly face a dilemma not unique to any particular reimbursement model. The health community has not adapted adequately to the notion that a growing portion of seniors need caring services rather than curative services. All of us, in capitated and non-capitated systems alike, need to reevaluate our approaches to meet the changing needs of our senior community. However, the capitated system that operates a coordinated range of services is in a more favorable position to address these needs. In fact, we have developed a number of innovative programs I'd be happy to describe during our question and answer session.

Finally, what unique contribution can capitated systems make to handling the problems facing the potentially frail and poor elderly? The greatest single risk for financial catastrophe facing each of us in our lifetime is the risk of institutionalization in a nursing home. You are more aware than I of the statistics surrounding the impoverishment caused by institutionalization. This past month we announced the first long term care insurance plan offered by a capitated system and I stand before you believing that if anyone can develop and institute an effective insurance plan for long term care, it will be capitated systems. We understand the incentives of capitation and we understand how to manage and provide services; insurance companies are unable to do either and are understandably uncomfortable about the financial risk attending such programs. As a result, few plans are available and those that are offered provide greatly restricted benefits.

The information I have presented I expect and hope will stimulate some further discussion. Let me first conclude with a summary of my position:

1. Capitation does not reduce quality of care,
2. The health community, whether capitated or not, is not and should not be responsible for addressing the needs of the very poor,
3. The health care community, whether capitated or not, is not well versed in how best to care for our frail elders, and
4. Capitated, integrated systems are in the best position to manage the services required by seniors, to research the changes required to address the needs of our aging population, and to prevent some of the current adverse effects of the fee-for-service health model.

Programs such as this session today purposely polarize a sensitive subject and provide useful stimulus for debate and thought. At the same time the lines between the traditionally dichotomous models of fee-for-service versus capitated systems are blurring. In closing, I would suggest we ultimately redirect our attention first to creating effective means of monitoring quality that assure identification and correction of problems that may occur and second, to adapting our health programs to the needs of an aging population for whatever payment mechanisms may be used. Thank you.